WICHITA STATE UNIVERSITY
CENTER FOR COMMUNITY SUPPORT AND RESEARCH

Learning Collaborative

Kansas Medicaid Health Homes Initiative

May 6, 2015
Rolling Hills Zoo Conference Center
Salina, KS

Welcome!

Kansas Department of Health and Environment

Wichita State University
Center for Community Support and Research

Wichita State University
Center for Community Support and Research

Why are we here?

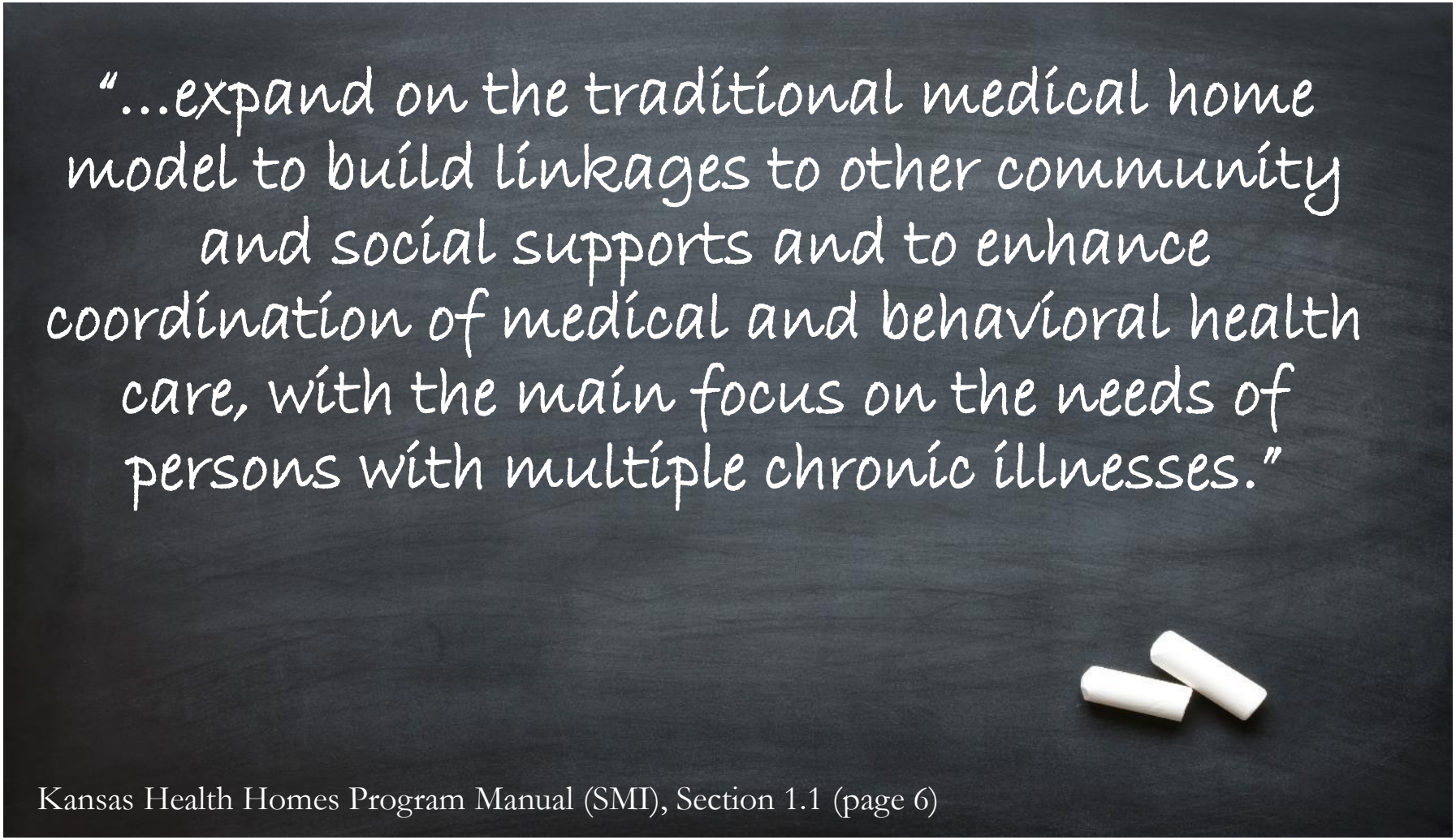
To celebrate successes,

conquer challenges,

and build a quality Health Homes system.

Building Connections

Purpose of Health Homes



Kansas Health Homes Program Manual (SMI), Section 1.1 (page 6)

Risks and Behaviors

drive **15** chronic conditions

1. Diabetes
2. Coronary Artery Disease
3. Hypertension
4. Back Pain
5. Obesity
6. Cancer
7. Asthma
8. Arthritis
9. Allergies
10. Sinusitis
11. Depression
12. Congestive Heart Failure
13. Lung Disease (COPD)
14. Kidney Disease
15. High Cholesterol

accounting for **80%** of total costs for all chronic illnesses worldwide

***Source**: 2010 World Economic Forum*

Quality Improvement Processes

Quality Improvement in Health Homes

Quality Improvement is outlined as a requirement in the KanCare Health Homes Program Manual (SMI)

Section 2.3
Item 6.g.
(page 22):

"Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;"

APPENDIX C: Kansas Health Homes Quality Goals and Measures

1. Reduce utilization associated with inpatient stays
2. Improve Management of Chronic Conditions
3. Improve Care Coordination
4. Improve transitions of care among primary care and community providers and inpatient facilities

http://www.mainequalitycounts.org/image_upload/BHHQIProjectTemplateCoreStandard9Web.pdf
http://www.mainequalitycounts.org/image_upload/Jan2015BHH%20WebinarSlides.pdf

Quality Assurance v. Quality Improvement

Quality improvement (QI) consists of *systematic* and *continuous* actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

	QA	QI
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention, monitor over time
Attitude	Required, defensive	Chosen, proactive
Focus	Outliers or "bad apples", individuals	Processes, systems, majority
Players	Selected departments	Organization wide, benchmarking
Disciplines	Within profession	Multidisciplinary approach
Scope	Medical profession focused	Patient care focused
Responsibility	Few	All

Four Key Principles in Successful QI

QI work as systems and processes

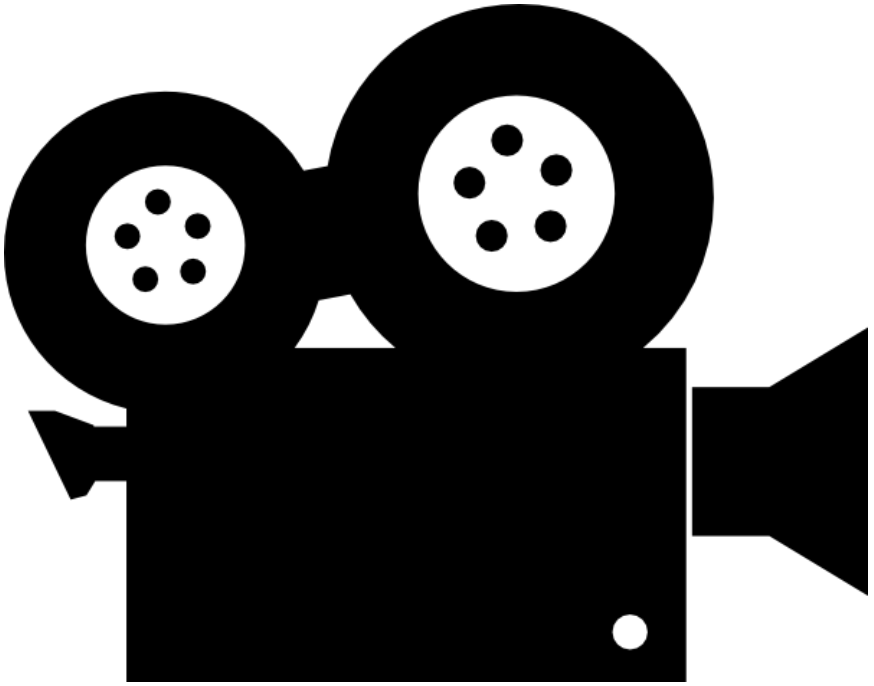
Focus on patients

Focus on being part of the team

Focus on using the data

http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

Quality Improvement in Health Care



Be prepared to share three things you noticed in the video that were

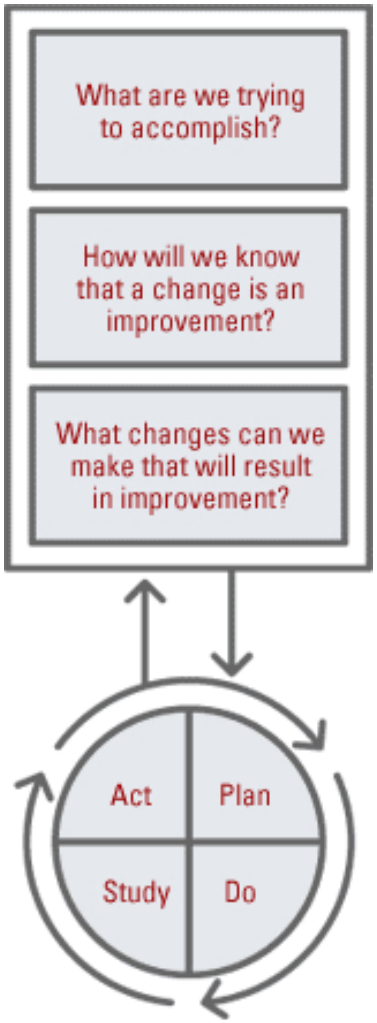
- New to you
- Worthy of additional discussion
- Challenging

Institute for Healthcare Improvement

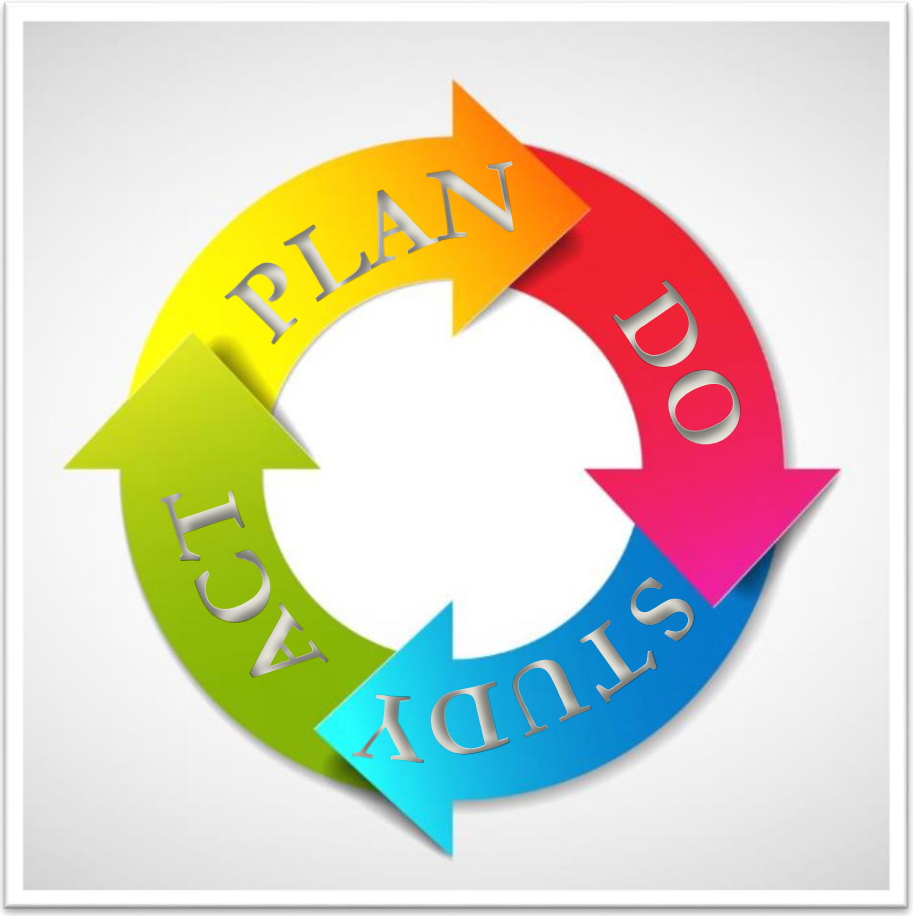
What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?

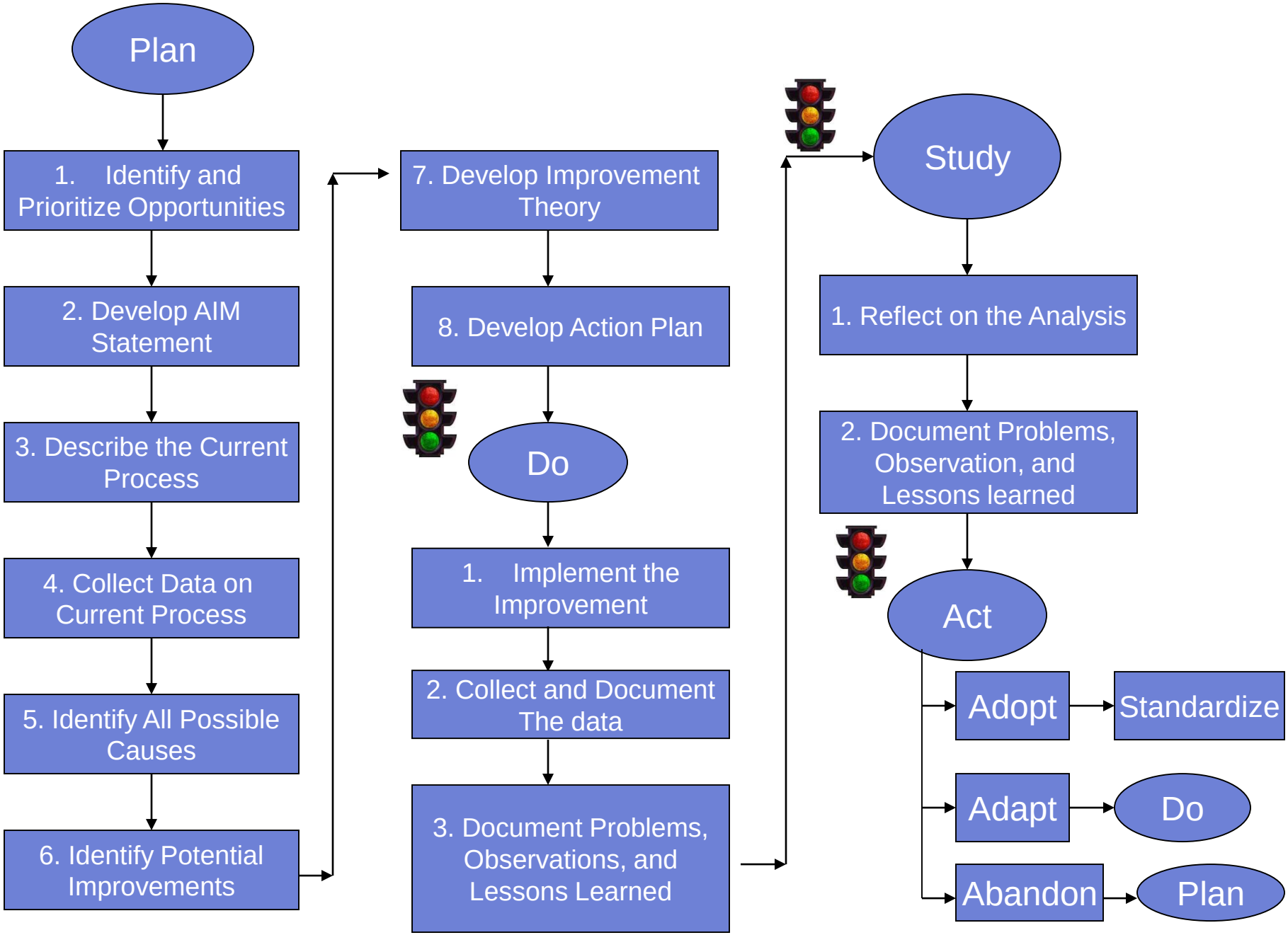


http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

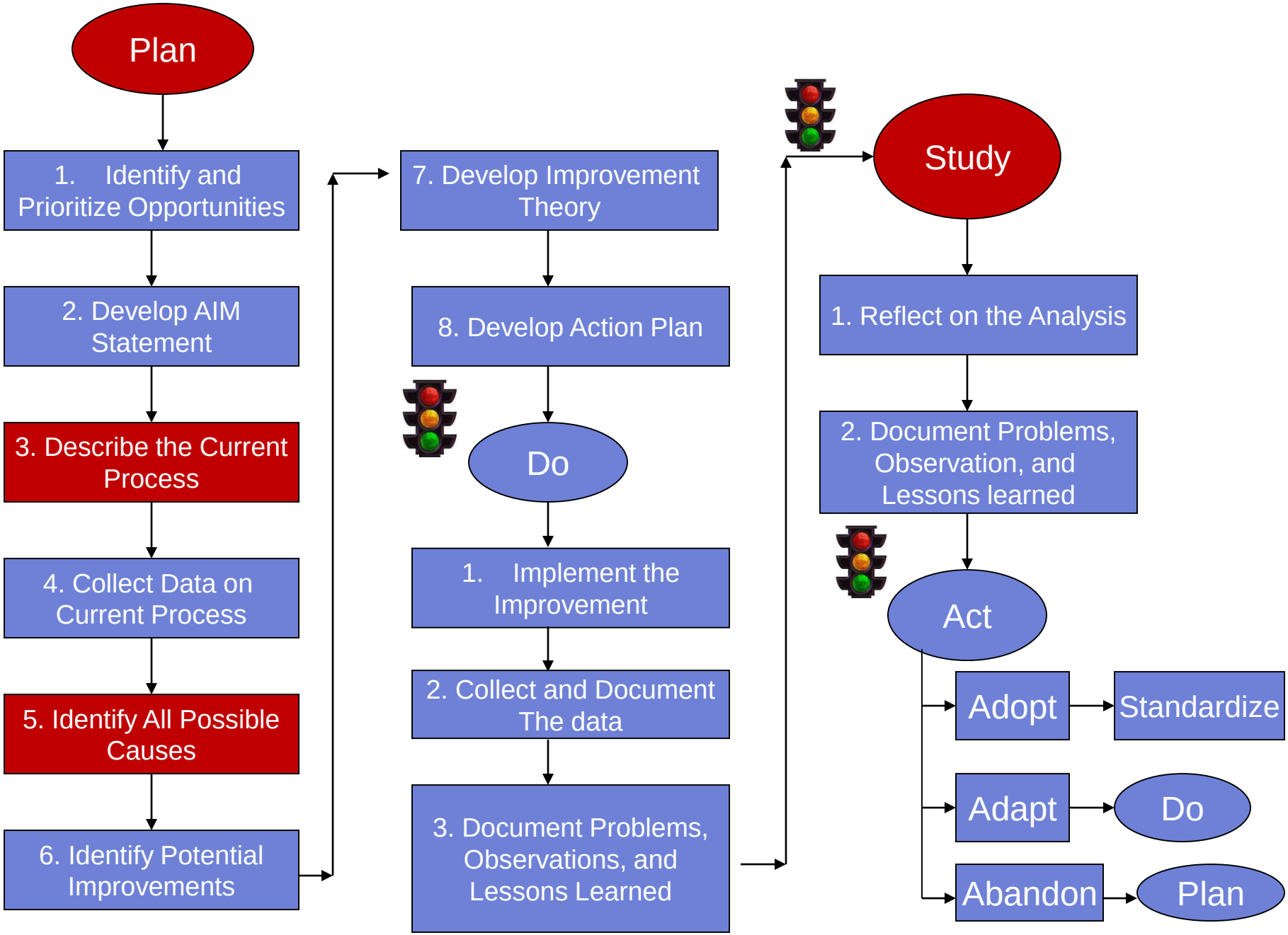


PDSA was made popular by Dr. Deming who is considered by many to be the “father of modern quality control”; however it was always referred to by him as the "Shewhart cycle.“

The continuous improvement phase of a process is how you make a change in direction. The change usually is because the process output is deteriorating or customer needs have changed.



Source: ABCs of the PDCA Cycle, G. Gorenflo and J. Moran, http://www.phf.org/pmqi/resources.htm



Source: ABCs of the PDCA Cycle, G. Gorenflo and J. Moran, http://www.phf.org/pmqi/resources.htm

If you can't describe what you are doing as a process, you don't know what you're doing.

(W. Edwards Deming)

“Plan” Step 3:
Describe the Current Process

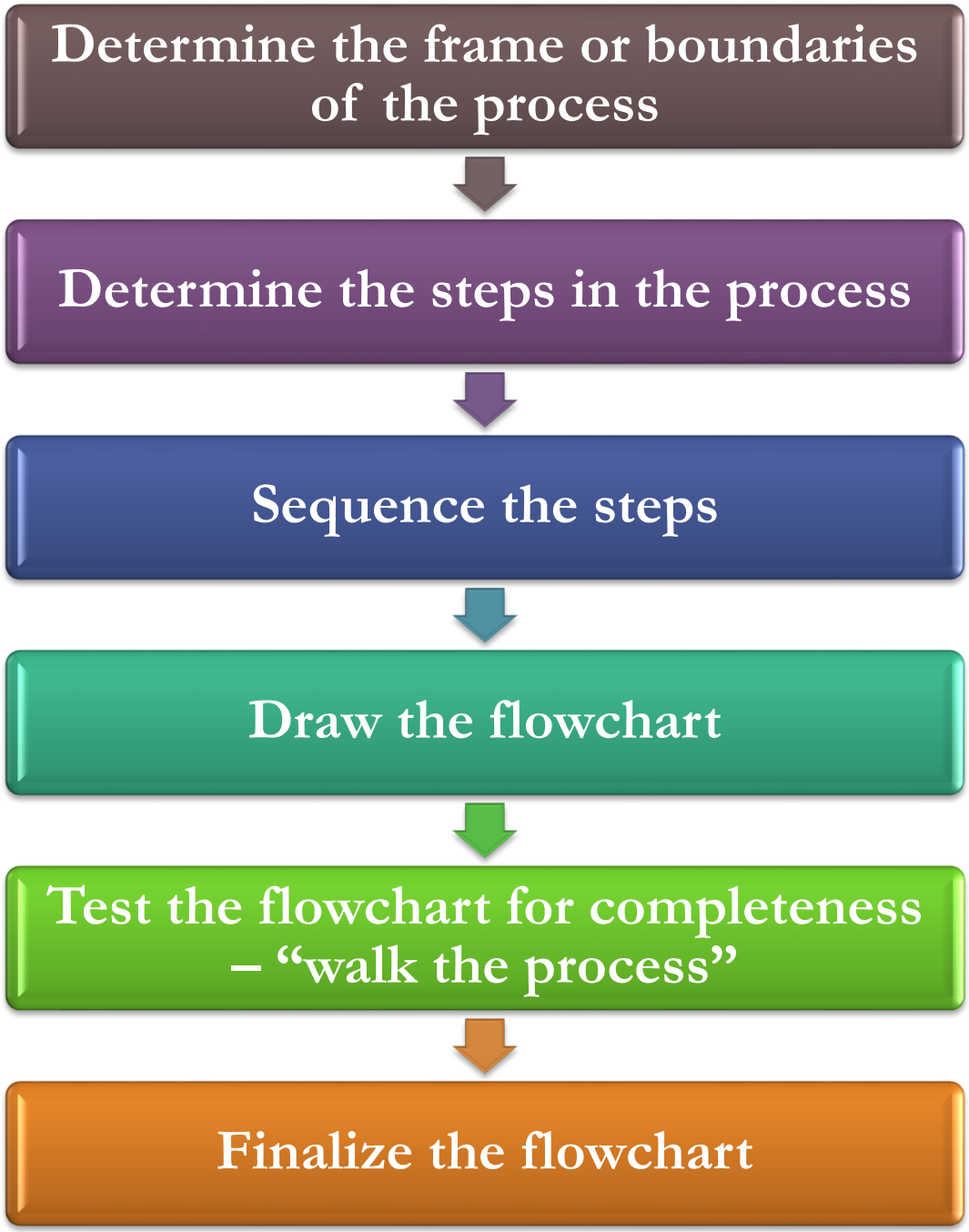
Flow Charts

"Plan Step 3: Describe the Current Process

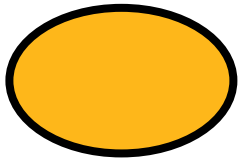
Flow Chart

- A diagram that represents the sequence of operations in a process

Steps in Constructing a Flow Chart



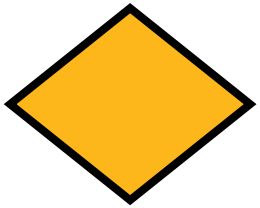
Flowchart Symbols



- Oval: Shows beginning or ending step in a process

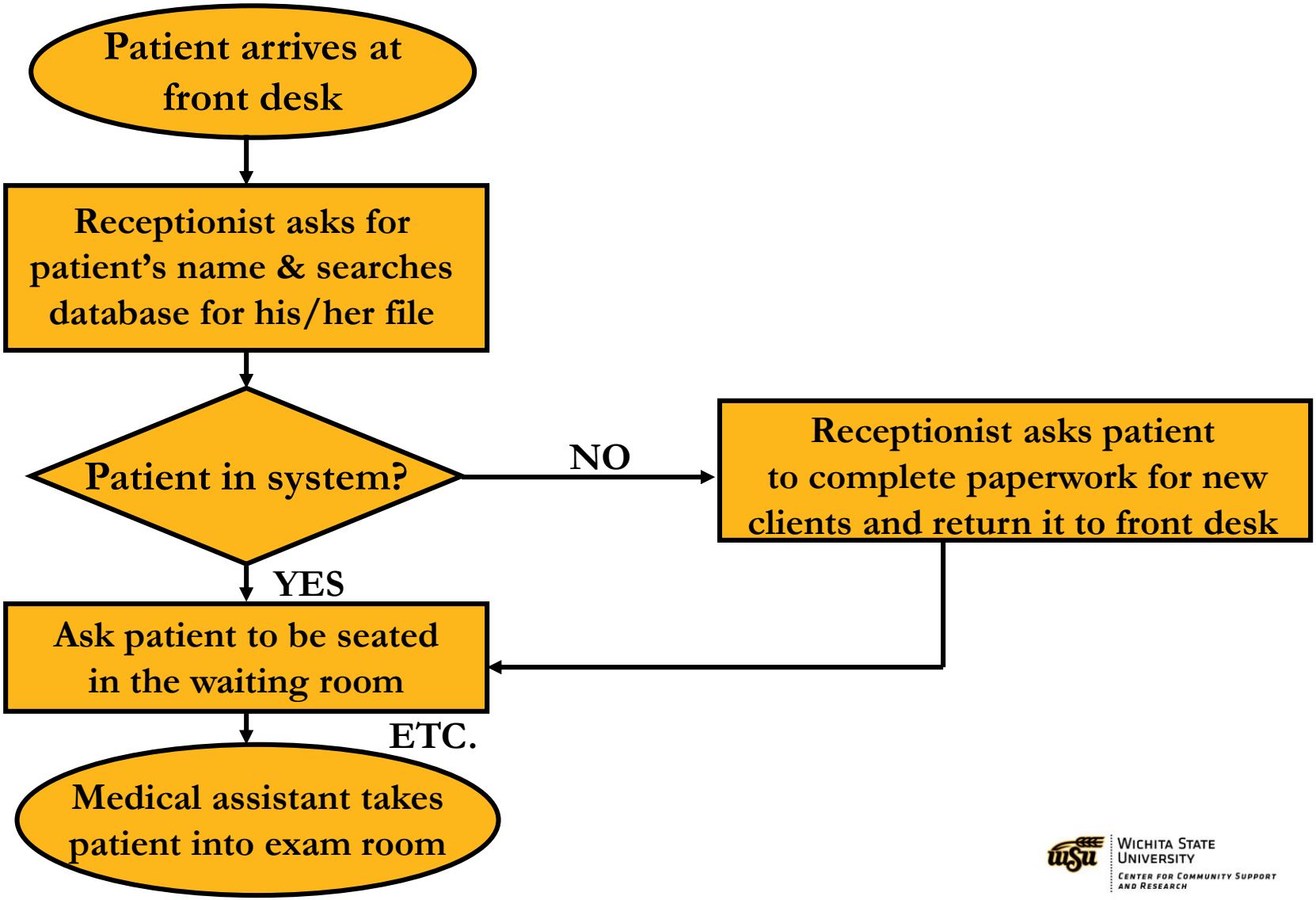
- Rectangle: Depicts particular step or task

- Arrow: Shows direction of process flow



- Diamond: Indicates a decision point

Flowchart Example

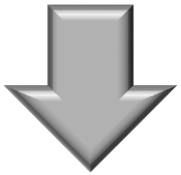


Flow Charting Exercise

Start

Alarm Goes Off

You are sound asleep and your alarm just went off at 6 AM this morning



Your assignment: Flow chart all the activities you have to do to get to the point where you open the door and leave for this meeting.

End

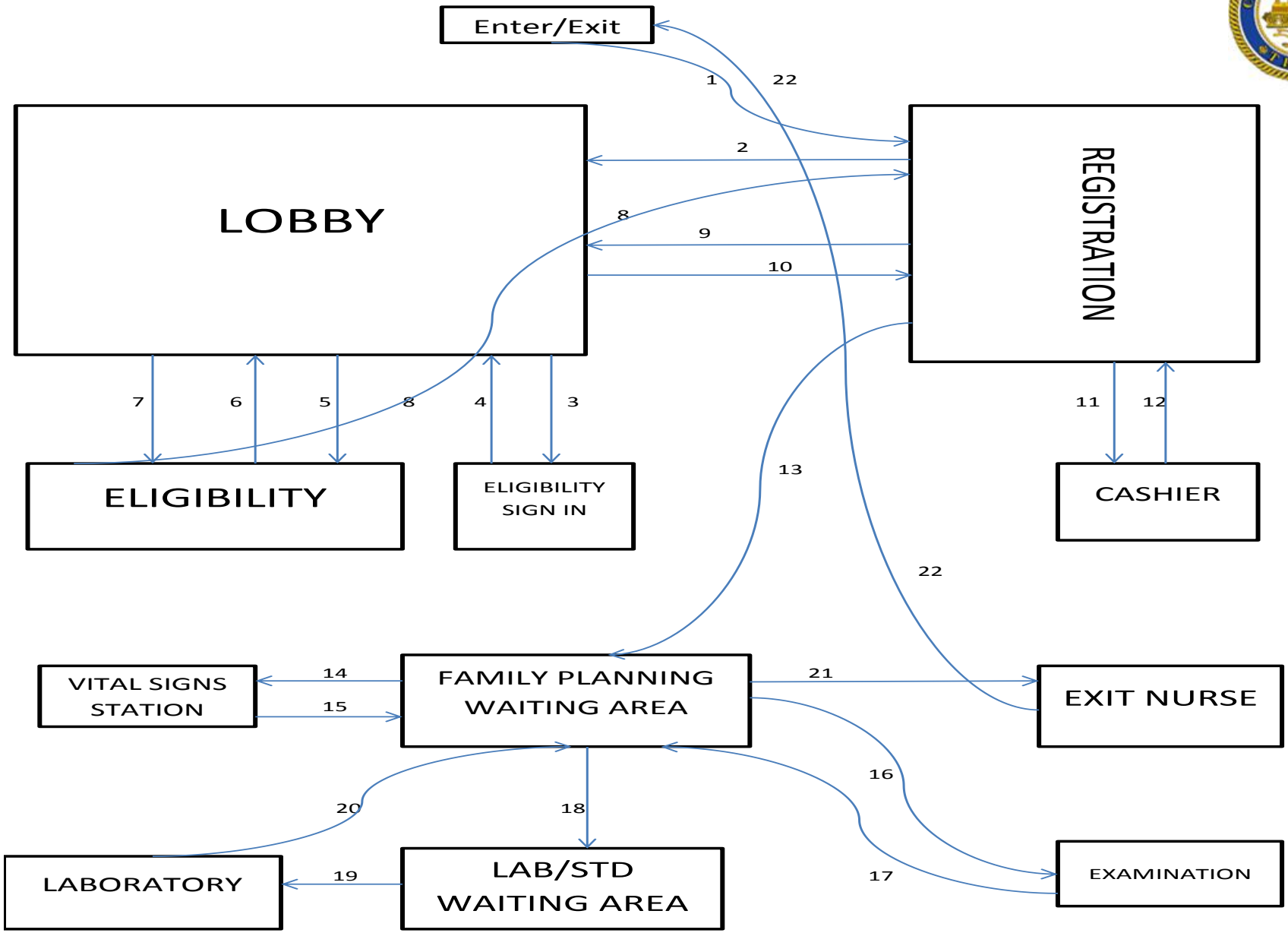
Open the door and leave

You open your door and leave for this meeting.

- Identify two steps that are not needed and should be eliminated.
- Identify two steps that should be added that would add value to the process.

Swim Lane Flow Chart

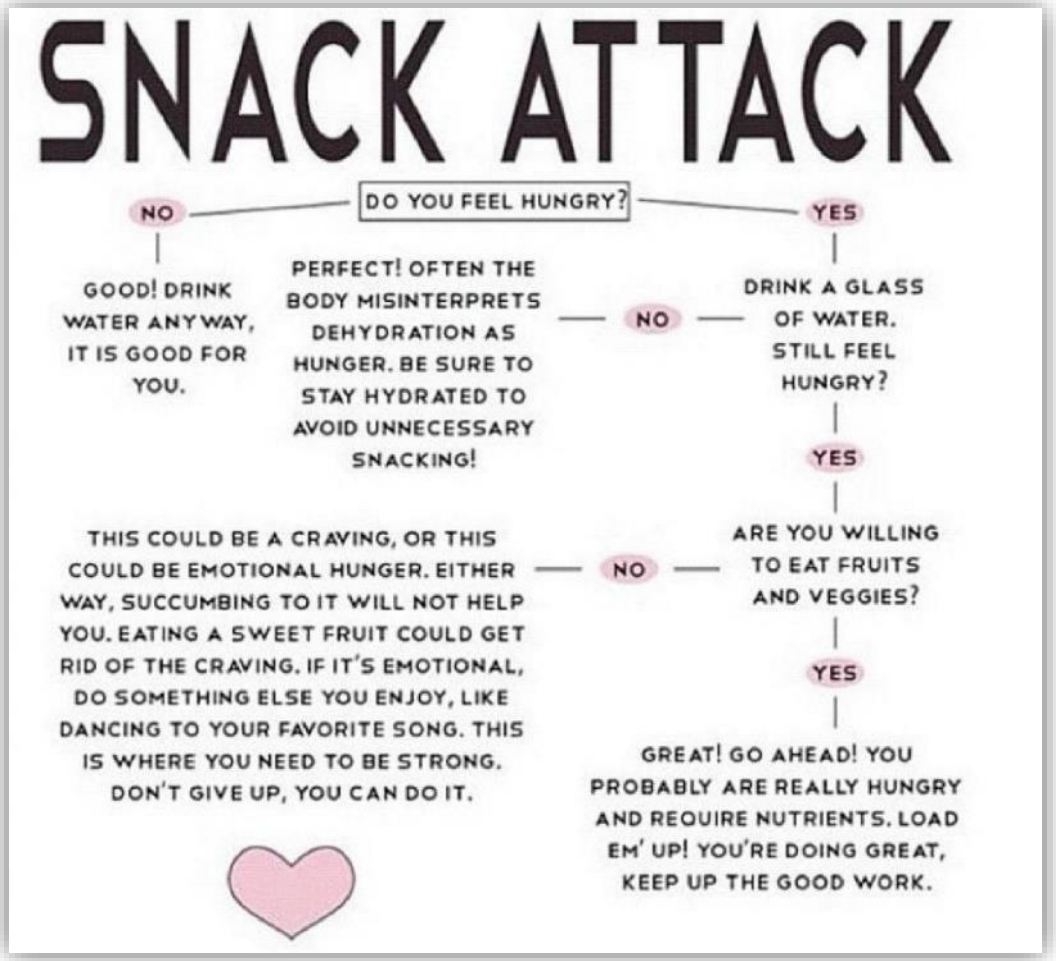
SUNNYSIDE HEALTH CENTER FAMILY PLANNING SPAGHETTI DIAGRAM



Test the Flow Chart

- ✓ Is the process being run the way it ***should*** be?
- ✓ Are people following the process ***as charted***?
- ✓ Are there ***complexities*** or ***redundancies***?

Flow Charts – Not just for QI anymore



“Plan” Step 5:
Identify all Possible Causes
Cause & Effect Diagrams

Purpose of Cause and Effect Diagram

Why use a Cause and Effect Diagram?

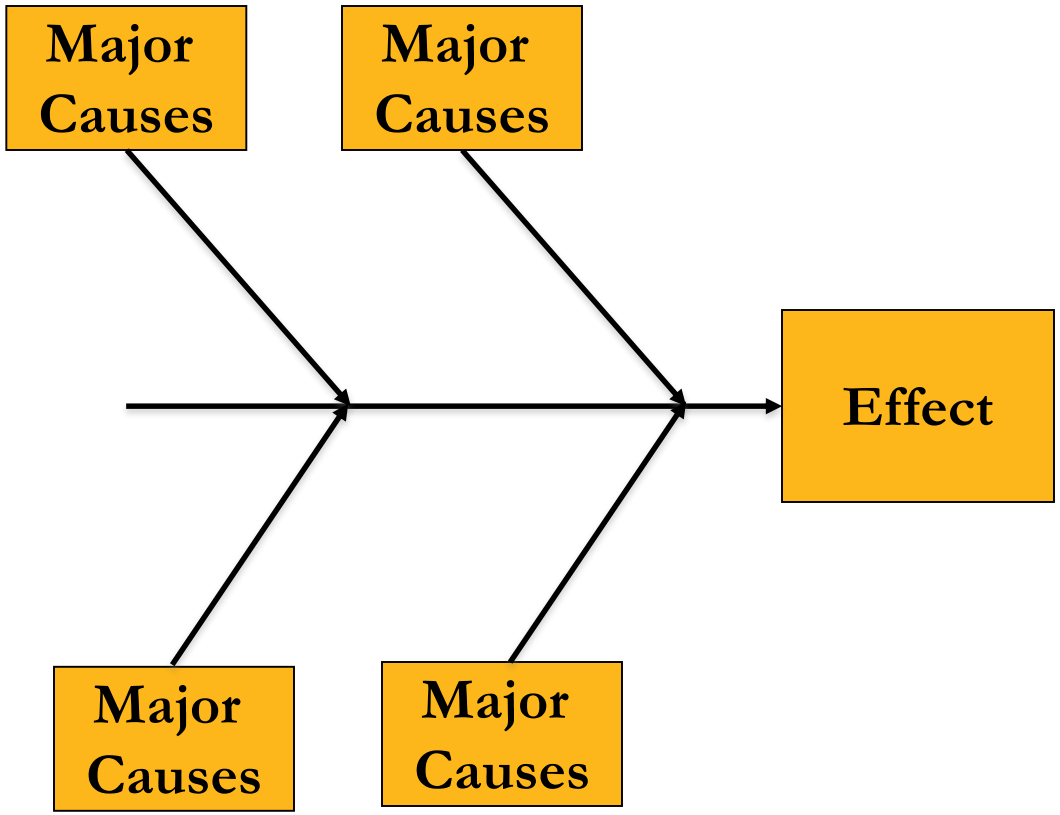
To allow a team to identify, explore, and graphically display increasing detail – all of the possible causes related to a problem or condition to discover its root cause(s).

What does it do?

- Enables a team to focus on the content of the problem versus the history of the problem or personal interests of the team.
- Creates a snapshot of the collective knowledge and consensus of a team around a problem.
- Focuses the team on causes, not symptoms.

Cause and Effect Diagrams: Construction

- Generate ideas as to what are the major causes of the effect
- Label these as the major branch headers
- Organizes group knowledge about causes of a problem and display the information graphically



Cause and Effect Diagrams: Causes

The four "M"s

- Methods
- Materials
- Machines
- Manpower

The four "P"s

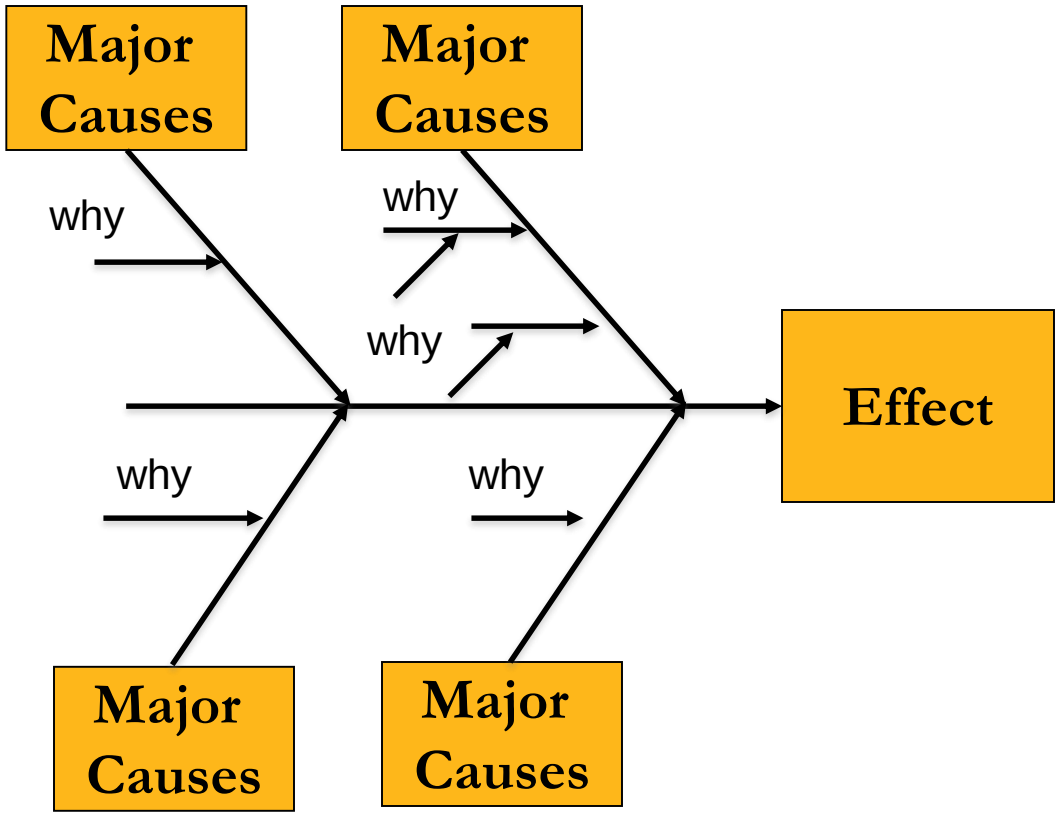
- Place
- Procedures
- Policies
- People

The four "S"s

- Surroundings
- Suppliers
- Systems
- Skills

Cause and Effect Diagrams: Construction

- For each major cause category brainstorm ideas as to what are the related sub-causes that might effect our issue
- Use the 5 "Why?" techniques when a cause is identified
- Keep repeating the question until no other causes can be identified
- List the sub-cause using arrows



Tips for Cause & Effect Development

- Consider drawing your fish on a flipchart or large dry erase board.
- Ask "Why does this happen?"
- Sticky notes– everyone participates
- Select a prioritization method
  - Voting with dots
  - Frequency of cause
  - Branch with most contributing factors

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf

Why Are Employees Late For Work?

- It is a question that management has wrestled with for a long time.
- Every time we think we have heard all the excuses someone invents another creative one.


YOU'RE JUST GETTING HERE?
IT'S ZERO DEGREES AND THE ROADS ARE ALL ICE.
Dilbert.com DilbertCartoonist@gmail.com
I DRANK SIX CUPS OF COFFEE BEFORE LEAVING THE HOUSE AND SAT IN TRAFFIC FOR TWO HOURS.
2-2-12 ©2012 Scott Adams, Inc./Dist. by Universal Uclick
YOU'RE THREE HOURS LATE.
I SPENT THE LAST HOUR STUCK TO A GUARDRAIL.

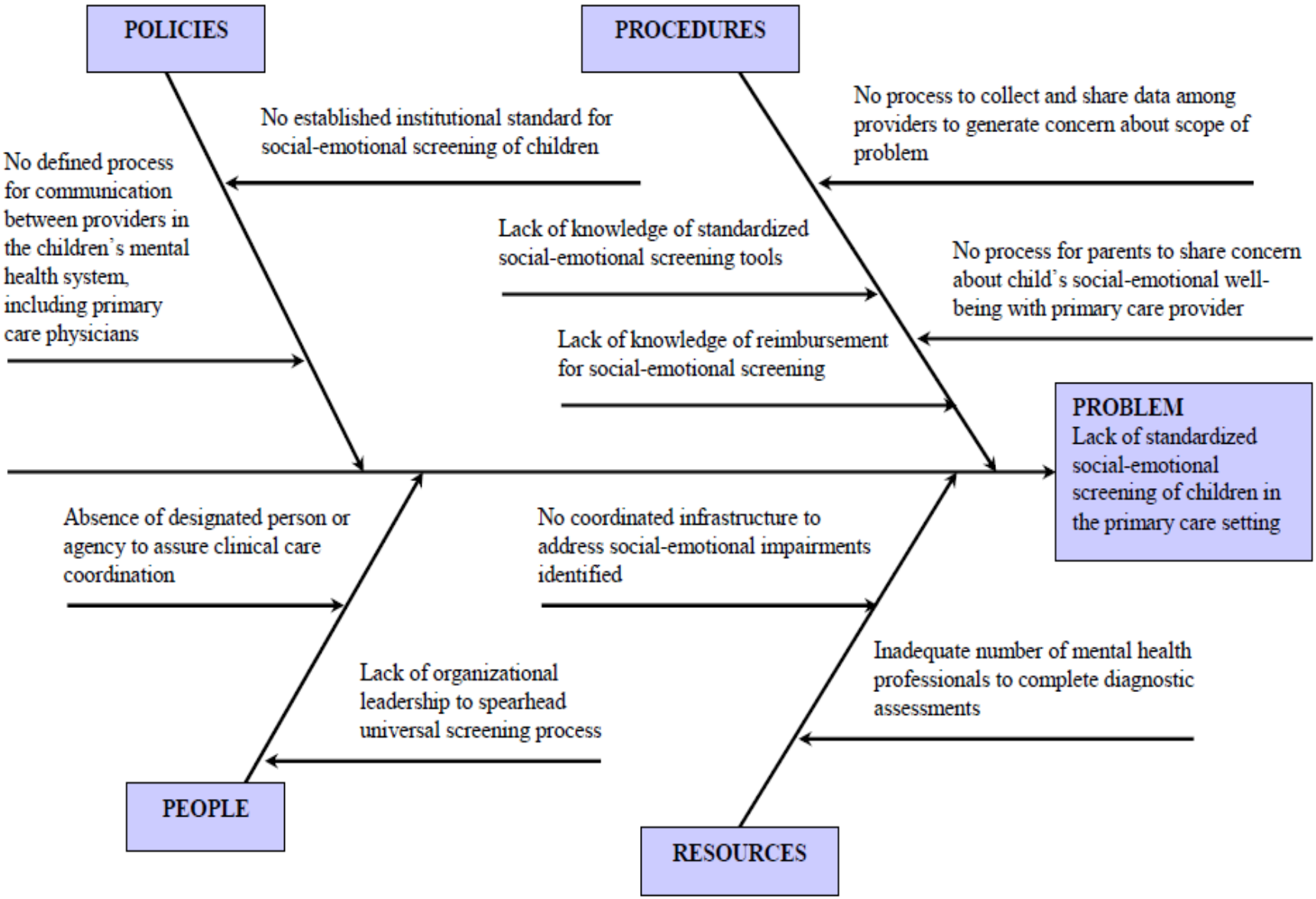
Cause & Effect Exercise

Practice with C&E

Effect: Eligible participants won't engage in Health Home services

Identify major cause categories	Identify sub-causes	Use 5 "Why"s (and "why does this happen?")

DOUGLAS COUNTY CHILDREN'S MENTAL HEALTH COLLABORATIVE
Cause & Effect Analysis



Study Phase: Storyboards

Storyboards

Tool for effectively presenting a team's work

- to other groups within the organization;
- to other organizations;
- to the larger community.

http://www.ihi.org/resources/Pages/Tools/Storyboards.aspx

Sample Storyboard Format—IHI

- **Organization Name, City, State**
- **Project Name**
- **Aim:** (Put aim statement here.)
- **Measures:** (List 3 to 5 key measures.)
- **Results:** (Include one or two of the key graphs — be sure that sample size and goals are on the graphs and that they are annotated.)
- **Changes Being Tested**

http://www.ihi.org/resources/_layouts/download.aspx?SourceURL=%2fresources%2fKnowledge+Center+Assets%2fTools+-+Storyboards_455f9626-d8d8-4b6f-96ca-714b78863abd%2fStoryboardTool.pdf

Creating a Diabetes Group Visit for Brazilian Immigrants

Monica DeMasi, MD[1,2,3], Sarah Messmer[1], Jessica Reader[2], Joshua St. Louis[2], Anna Pancheshnikov[1], Patricia Alves[3], Meredith Steuer, Thomas Jaeger and Kai Huang[1]

1. Harvard Medical School, 2. Tufts University School of Medicine, 3. Union Square Family Health (Cambridge Health Alliance)

Problem

There is a large population of Brazilians in Boston Area, particularly in the area that Union Square Family Health serves. However, despite access to a wide range of services, Brazilian diabetics have worse outcomes than other populations.

Handling the complexities of chronic illness and meeting cultural needs is difficult within the setting of a regular fifteen-minute visit. In addition, provider and clinical staff felt that cultural barriers prevented the provision of adequate care and disease education. These two factors appeared to be linked to poor Diabetes outcome indicators in the Brazilian population. Established group visit curriculums have been shown to improve outcome in the general population, but there was no such model to use that had been adapted to the specific needs of Brazilian immigrants.

Aim

The aims of the project were to 1) reduce HbA1c by 0.5% within 6 months for all participants , 2) decrease the blood pressure of 60% of hypertension patients not at goal blood pressure by 10% 3) decrease LDL by 10% for all patients not at goal cholesterol 4) increase rate of flu vaccine and pneumovax to 100% 5) increase rate of eye exams and foot exams to 100% 6) increase patient satisfaction with care and self-knowledge of Diabetes.

Project Design

We assembled a team of clinic staff (family physician and medical assistant), medical students and groups of providers (registered nurses, pharmacy, community health, social work). We received project implementation and change management support from the Harvard Center for Primary Care Innovation Fellows' Program. Our group medical visit was largely based on the diabetes self-management program developed at the Stanford Patient Education Research Center.* This model was adapted based on focus groups of providers and in-depth interviews of patients. [2] We shared our findings at CHA poster sessions. In our next iteration, graduates of the program will serve as peer advisors for the next cohort.

Intervention

- Six weekly 2-hour sessions, conducted in Portuguese.
- Staffed by a family physician, a medical assistant, and one or more students.
- Group activities using motivational interviewing techniques.
- Topics covered include:
- Healthy eating, physical activity
- Depression and stress management
- Medications, lab tests and results
- Interacting with the health care system
- Completed eye and foot exams

Measurement of Improvement

We evaluated our intervention using both quantitative and qualitative data. Quantitative data included blood glucose, HbA1c, LDLc, weight, and blood pressure. Qualitative data was based on responses to a patient survey measuring knowledge of and attitudes/beliefs about diabetes. In addition, patients from first cohort plan to return and act as peer mentors to the next cohort of patients which we believes signifies approval of the program.

Lessons Learned and Message for Others

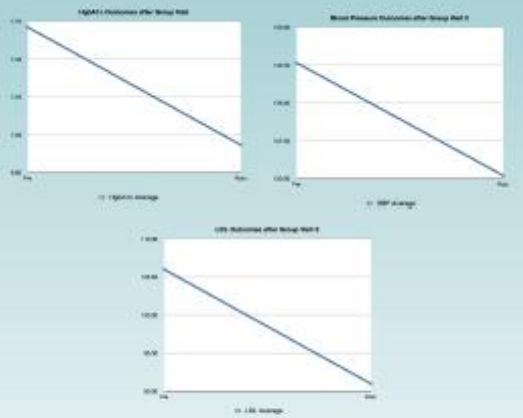
Though immigrant populations often face multiple barriers to good quality care, with a well-designed group visit intervention, these patients can achieve excellent health outcomes.

The adapted Stanford Model provide good results and outcomes for non-english speaking populations.

Streamlining recruitment strategies: we must scale up to include more patients and generate a larger data set.

BRAZILIANS IN BOSTON AREA: DEMOGRAPHICS	
Percentage of new immigrants in Boston	19.10%
Number in Boston	6,822
States of origin in Brazil	Minas Gerais, Parana, Goias, Santa Catarina
Male	53%
Single	45%
Between ages 20-34	50%
Have high school diploma only	28%
Work in services	42%
Unemployed	3%
Self-Employed	16%
Middle Class or Higher	20.60%

Reference: Boston Redevelopment Authority, 2007.



PATIENT EXPERIENCES

"It didn't change too much, just the way I eat, the amount of exercise I do and how to take my medications."
"Participant OP

"The group completely changed the way I see my disease. I now realize that my own behavior is the most important part of my treatment."
"Participant SG

BRAZILIANS AT UNION SQUARE FAMILY HEALTH: 2012	
LANGUAGES	
English speakers	46%
Portuguese speakers	Staff med: 30%[1]
Spanish speakers	13%
Haitian Creole speakers	2%
Other language speakers	9%
INSURANCE COVERAGE	
Health safety net	10%
Medicaid / Mass Health plans	43%
Medicare	5%
Private insurance	40%

[1]A sizable portion of Brazilians at USFH list English even though they prefer to receive care in Portuguese. This number is therefore an underestimate.

http://www.ihi.org/education/Conferences/Forum2013/Documents/OSG_12613.pdf

Sample Storyboard Format—NNPHI

PLAN -- Identify an opportunity and plan for improvement

1. **Getting Started**
2. **Assemble the Team**
3. **Examine the Current Approach**
4. **Identify Potential Solutions**
5. **Develop an Improvement Theory**

National Network of Public Health Institutes

Wichita State University
Center for Community Support and Research

Sample Storyboard Format—NNPHI

DO -- Test the Theory for Improvement

6. **Test the Theory**

CHECK -- Use Data to Study Results of the Test

7. **Check the Results**

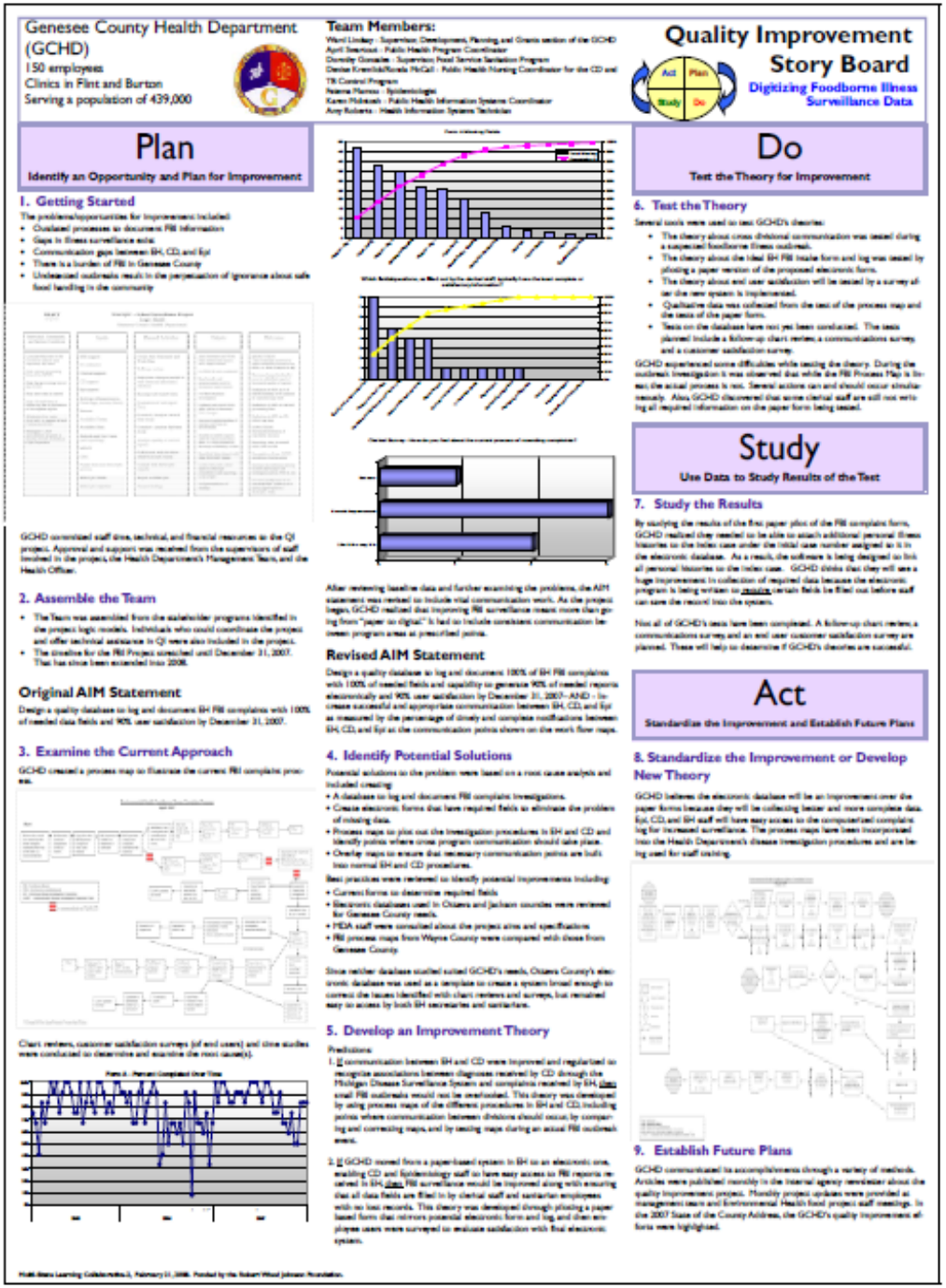
ACT -- Standardize the Improvement and Establish Future Plans

8. **Standardize the Improvement or Develop New Theory**
9. **Establish Future Plans**

National Network of Public Health Institutes

Wichita State University
Center for Community Support and Research

http://nnphi.org/tools/public-health-performance-improvement-toolkit-2



Genesee County Health Department (GCHD)
150 employees
Clinics in Flint and Burton
Serving a population of 439,000

Team Members:

Quality Improvement Story Board

Digitizing Foodborne Illness Surveillance Data

Plan

Identify an Opportunity and Plan for Improvement

1. Getting Started

2. Assemble the Team

Original AIM Statement

3. Examine the Current Approach

Do

Test the Theory for Improvement

6. Test the Theory

Study

Use Data to Study Results of the Test

7. Study the Results

Revised AIM Statement

4. Identify Potential Solutions

5. Develop an Improvement Theory

Act

Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory

9. Establish Future Plans

http://www.nnphi.org/CMSuploads/Michigan_QI_Story_Boards-11699.pdf

Successful Collaborations

FAMILY SERVICE & GUIDANCE CENTER

Improving children's lives since 1904

Mirror, Inc

Safe, Healthy People in Strong Communities

Stormont-Vail HealthCare

Valeo

Behavioral Health Care

Learning Collaborative Webcasts

June 2, 2015 – 3:00 p.m.

Health Action Plan Webinars:

Summer 2015 & Winter 2016

Community of Practice Webcast:

May 19 – 11:00 a.m. – 12:00 p.m.

KanCare

REACH
healthcare foundation

Sunflower Foundation
HEALTH CARE FOR KANSANS

Wichita State University
Center for Community Support and Research

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